THE INDIVIDUALIZED SUPPORT PLAN

THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-81. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.

INCOMPLETE ISP

Name of Individual_____ **Social Security #**_____ ☐ **Female** ☐ **Male**

Name of Facilitator_____ **Date of Support Plan**_____ / /

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

Medical Insurance

Insurance #1 => _____
Insurance #2 => _____
Insurance #3 => _____

Individual's Personal and Demographic Information

Last Name_____ **First Name**_____ **MI**_____

Address _____

City _____ **State**_____ **Zip** _____

DOB _____ / / **RID #**_____ **Legal Status**_____

Living Arrangement _____

The Individual is currently ☐ **In School** ☐ **Employed** ☐ **Other (Specify)**

Individual's Diagnosis

Primary Diagnosis => _____
Other Diagnosis => _____
Other Diagnosis => _____

Individual's Emergency Contacts

Name _____ **Phone #** _____ **Relationship** _____

Address _____

Alternate contact method

Name _____ **Phone #** _____ **Relationship** _____

Address _____

Alternate contact method

Name _____ **Phone #** _____ **Relationship** _____

Address _____

Alternate contact method

**** Attach Person Centered Planning Profile Information ****

THE INDIVIDUALIZED SUPPORT PLAN

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Date of Support Plan ____/ /____

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Outcome towards which this Individualized Support Plan will work

Desired Outcome:

_____

Current Status:

_____

Past Experience:

_____

Proposed Strategy/Activity

Responsible Party

Time Frame

Progress Notes

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Statement of Agreement

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

I have been involved in the development of my Individualized Support Plan and I agree with this Plan.

I know I can appeal to the DDRS if I disagree with how this plan is put into action

Signed _____ Date _____

Individual for whom this plan was written *Date signed*

Signed _____ Date _____

Guardian of Individual, if applicable *Date signed*

Level of team meeting involvement of individual for whom plan is written:

Individualized Support Plan Participants

Participant	Relationship	Date Plan Was Sent	Sent Via
		/ /	Email-postal-fax-InPerson
		/ /	Email-postal-fax-InPerson
		/ /	Email-postal-fax-InPerson
		/ /	Email-postal-fax-InPerson
		/ /	Email-postal-fax-InPerson
		/ /	Email-postal-fax-InPerson
		/ /	Email-postal-fax-InPerson
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		/ /	Email-postal-fax-InPerson
		/ /	Email-postal-fax-InPerson

Name of Individual_____

Date of Support Plan ____/ /____

INCOMPLETE ISP

Meeting Issues and Requirements

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

The Individualized Support Plan team shall check any of the following Health and Behavioral Issues that may concern the individual and explain how they are met or addressed by this plan.

Issue	Issue Response	Comment
Is a provider needed to provide health and behavioral support (Name the provider responsible)?	Yes-No	
Seizures or History of Seizures	Yes-No	
Allergies or History of Allergies	Yes-No	
Dentures	Yes-No	
Chewing Difficulties	Yes-No	
Swallowing Difficulties	Yes-No	
Dining Difficulties	Yes-No	
Vision Difficulties	Yes-No	
Hearing Difficulties	Yes-No	
Speaking or Mode of Communication Issues	Yes-No	
Behavior Issues	Yes-No	
Medication or Self -medication Issues	Yes-No	
Does individual have issues discovered through review of Incident Reports?	Yes-No	
Does individual require Lab Testing?	Yes-No	
Does individual have any Other chronic conditions or healthcare issues?	Yes-No	

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Meeting Issues and Requirements

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The Individualized Support Plan team shall check any of the following Health Care Professional Issues that may concern the individual and explain how they are met or addressed by this plan.

Issue	Issue Response	Comment
Family physician	Yes-No	
Dentist	Yes-No	
Other needed specialists (seizures, mental health issues, etc.)	Yes-No	

Name of Individual_____

Date of Support Plan ____/ /____

INCOMPLETE ISP

Meeting Issues and Requirements

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The Individualized Support Plan team must show which of the following Safety and Environmental Requirements have been met by this Plan, and how.

Issue	Issue Response	Comment
Is a provider needed to provide environmental and living arrangement support ? If a provider is supplying that support, please name the provider responsible in the comment.	Yes-No	
Carbon Monoxide Detectors	Yes-No	
Smoke Detectors	Yes-No	
Emergency Phone Numbers posted prominently	Yes-No	
Emergency Evacuation Plan & Routes	Yes-No	
Fire Extinguishers	Yes-No	
Anti-Scalding Devices	Yes-No	
Personal Emergency Response System	Yes-No	
Is there Insurance?	Yes-No	
If Special Devices and Home Modifications are required, are they present?	Yes-No	
Is there a Current Photograph in the Personal File?	Yes-No	
Is adequate Transportation being provided?	Yes-No	
Are the Individual's Property / Financial Resources being properly managed? If a provider is maintaining this information even if it is being properly managed, please enter the provider's name in the comment.	Yes-No	

Name of Individual_____

Date of Support Plan ____/ /____

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Meeting Issues and Requirements

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The Individualized Support Plan team must show which of the following Provider Requirements have been met by this Plan, and how.

Issue	Issue Response	Comment
Was the 1st Case Manager contact after ISP implementation done timely?	Yes-No	
Are Frequency of Case Manager monitoring visits at least every 90 days?	Yes-No	
Is individual's personal file being maintained? Please Name the provider responsible.	Yes-No	
Are records being Analyzed and Updated properly?	Yes-No	
MEDICAL CONDITION	Yes-No	
BEHAVIOR STATUS	Yes-No	
DEVELOPMENTAL STATUS	Yes-No	
RISK OF TREATMENT	Yes-No	

Name of Individual_____

Date of Support Plan ____/ /____

INCOMPLETE ISP

Optional Attachment: Resources

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

This individual is currently receiving funding support from the following sources:

- ☐ DFC
- ☐ BDDS
- ☐ DOE Wrap-Around
- ☐ Vocational Rehab
- ☐ CHOICE
- ☐ Medicaid Waiver
- ☐ SSI
- ☐ SSDI
- ☐ Medicaid
- ☐ Medicare
- ☐ Trust Fund
- ☐ Employment Earnings

The team and the individual discussed funding support from the following sources:

- ☐ DFC
- ☐ BDDS
- ☐ DOE Wrap-Around
- ☐ Vocational Rehab
- ☐ CHOICE
- ☐ ALL Medicaid Waivers
- ☐ SSI
- ☐ SSDI
- ☐ Medicaid
- ☐ Medicare
- ☐ Trust Fund
- ☐ Employment Earnings

This individual does not desire funding support from the following sources:

- ☐ DFC
- ☐ BDDS
- ☐ DOE Wrap-Around
- ☐ Vocational Rehab
- ☐ CHOICE
- ☐ Medicaid Waiver
- ☐ SSI

Name of Individual_____

Date of Support Plan ____/ /____

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Optional Attachment: Resources

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This individual does not desire funding support from the following sources:

- ☐ SSDI
- ☐ Medicaid
- ☐ Medicare
- ☐ Trust Fund
- ☐ Employment Earnings

This individual has applied for funding support from the following sources:

- ☐ DFC
- ☐ BDDS
- ☐ DOE Wrap-Around
- ☐ Vocational Rehab
- ☐ CHOICE
- ☐ Medicaid Waiver
- ☐ SSI
- ☐ SSDI
- ☐ Medicaid
- ☐ Medicare
- ☐ Trust Fund
- ☐ Employment Earnings

This individual is currently on a waiting list for the following supports:

- ☐ DFC
- ☐ BDDS
- ☐ DOE Wrap-Around
- ☐ Vocational Rehab
- ☐ CHOICE
- ☐ Medicaid Waiver
- ☐ SSI
- ☐ SSDI
- ☐ Medicaid
- ☐ Medicare
- ☐ Trust Fund
- ☐ Employment Earnings